

State:	Arkansas	Filing Company:	Aviva Life and Annuity Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	Applications - 2013		
Project Name/Number:	Applications - 2013/Applications - 2013		

Filing at a Glance

Company:	Aviva Life and Annuity Company
Product Name:	Applications - 2013
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	01/11/2013
SERFF Tr Num:	NDPL-128752128
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	APPLICATIONS - 2013
Implementation	On Approval
Date Requested:	
Author(s):	Laurel Colton, Ben Warren, Jeff Heagel, Megan Phillips, Megan Flynn Bickel
Reviewer(s):	Linda Bird (primary)
Disposition Date:	01/16/2013
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Applications - 2013
Project Name/Number: Applications - 2013/Applications - 2013

Filing Company: Aviva Life and Annuity Company

General Information

Project Name: Applications - 2013	Status of Filing in Domicile: Pending
Project Number: Applications - 2013	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Pending in our domiciliary state, Iowa
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/16/2013
	State Status Changed: 01/16/2013
Deemer Date:	Created By: Jeff Heagel
Submitted By: Megan Flynn Bickel	Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are the applications and conditional receipts listed below. These new forms will be utilized with our new and existing indexed universal life, universal life, joint universal life, whole life, and term products. These applications may be used by an existing policyowner to complete one or more desired transactions, if the transaction is applicable to the existing policy. These applications will be used in paper format only.

18444 (6/13) - Life Insurance Application
18458 (6/13) – Joint Life Insurance Application
18465 (6/13) – Term Conversion Application
18472 (6/13) – Supplemental Application
18479 (6/13) – Non-Medical Questionnaire
18486 (6/13) – Medical Examination
15876 (6/13) – Conditional Life Insurance Agreement
18089 (6/13) – Conditional Joint Life Insurance Agreement

Also submitted for your review and approval is the underwriting questionnaire listed below. This form may be added to any current or future individual life contract where it is determined that additional information is needed.

18516 (6/13) – Financial Questionnaire

Enclosed for informational purposes is the Producer's Report for the Life Insurance Application and Joint Life Insurance Application to be used in conjunction with these applications. The Producer's Report includes the required agent/producer replacement question.

These forms are new and do not replace any forms previously approved by your department. To the best of our knowledge, no part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

At some time in the future, it may be necessary for us to change the format, fonts, page breaks, etc. in the forms in order to accommodate new technology or new printing equipment. We reserve the right to make these types of changes without re-filing as long as there is no change in the text of the forms. However, any such accommodation will not result in the use of a font or type style or size which would violate any state law or regulation.

These forms are produced from our Automated Policy Assembly Laser system and are in final print.

If you have any questions regarding this submission, please contact me at 515-342-6353 or e-mail me at jeff.heagel@avivausa.com.

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Applications - 2013
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Filing Company: Aviva Life and Annuity Company

Company and Contact

Filing Contact Information

Jeff Heagel, Product Compliance Analyst jeff.heagel@avivausa.com
7700 Mills Civic Parkway 515-342-3286 [Phone]
West Des Moines, IA 50266-3862

Filing Company Information

Aviva Life and Annuity Company	CoCode: 61689	State of Domicile: Iowa
7700 Mills Civic Parkway	Group Code: 44	Company Type:
West Des Moines, IA 50266-3862	Group Name:	State ID Number:
(800) 800-9882 ext. [Phone]	FEIN Number: 42-0175020	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$450.00
Retaliatory?	No
Fee Explanation:	\$50.00 X 9 forms = \$450.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
Aviva Life and Annuity Company	\$450.00	01/11/2013	66476617

SERFF Tracking #:	NDPL-128752128	State Tracking #:		Company Tracking #:	APPLICATIONS - 2013
State:	Arkansas	Filing Company:	Aviva Life and Annuity Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	Applications - 2013				
Project Name/Number:	Applications - 2013/Applications - 2013				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/16/2013	01/16/2013

State: Arkansas

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Applications - 2013

Project Name/Number: Applications - 2013/Applications - 2013

Filing Company:

Aviva Life and Annuity Company

Disposition

Disposition Date: 01/16/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Certifications		Yes
Supporting Document	Explanation of Variability		Yes
Supporting Document	Agent Reports (Filed for Informational Purposes Only)		Yes
Form	Life Insurance Application		Yes
Form	Joint Life Insurance Application		Yes
Form	Term Conversion Application		Yes
Form	Supplemental Application		Yes
Form	Non-Medical Questionnaire		Yes
Form	Medical Examination		Yes
Form	Conditional Life Insurance Agreement		Yes
Form	Conditional Joint Life Insurance Agreement		Yes
Form	Financial Questionnaire		Yes

State: Arkansas

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

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Filing Company:

Aviva Life and Annuity Company

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Life Insurance Application	18444 (6/13)	AEF	Initial		52.900	18444 (6-13) LifeApp_Generic FINAL.pdf
2		Joint Life Insurance Application	18458 (6/13)	AEF	Initial		50.000	18458 (6-13) JointLifeApp_Generic FINAL.pdf
3		Term Conversion Application	18465 (6/13)	AEF	Initial		50.100	18465 (6-13) SimpTermConv_Generic FINAL.pdf
4		Supplemental Application	18472 (6/13)	AEF	Initial		50.100	18472 (6-13) SuppApp_Generic FINAL.pdf
5		Non-Medical Questionnaire	18479 (6/13)	AEF	Initial		50.400	18479 (6-13) NonMedical_Generic FINAL.pdf
6		Medical Examination	18486 (6/13)	AEF	Initial		51.900	18486 (6-13) AppMedicalExam_Generic FINAL.pdf
7		Conditional Life Insurance Agreement	15876 (6/13)	AEF	Initial		50.500	15876 (6-13) ConditionalReceipt_Generic FINAL.pdf

SERFF Tracking #:

NDPL-128752128

State Tracking #:

Company Tracking #:

APPLICATIONS - 2013

State: Arkansas

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Applications - 2013

Project Name/Number: Applications - 2013/Applications - 2013

Filing Company:

Aviva Life and Annuity Company

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
8		Conditional Joint Life Insurance Agreement	18089 (6/13)	AEF	Initial		50.500	18089 (6-13) JointConditionalLifeInsAgmt_Generic FINAL.pdf
9		Financial Questionnaire	18516 (6/13)	AEF	Initial		54.100	18516 (6-13) Financial_Generic FINAL.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Life Insurance Application

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway
West Des Moines, IA 50266-3862]
Life Customer Contact Center – Tel:[800 800 9882]Fax:[800 531 0038]

AGENT/PRODUCER CODE & NAME:

A. INFORMATION ABOUT THE PROPOSED INSURED

First Name	M. I.	Last Name	Suffix	Is Proposed Insured also the Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address*		City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip	Country
Social Security Number		Date of Birth (MM/DD/YY)	Birth State		
Personal Phone () -		Business Phone () -	E-Mail		
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower		Maiden Name		
U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a resident or citizen of a country other than the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete the next line)			
Country of Birth	Country of Residency	Length of time in the U.S.		Type of Visa	
Proposed Insured's Driver's License or other government issued photo ID:					
Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /	
Employer Name	Employer Address, City, State, Zip				
Occupation/Duties		Length of time at current employer	Phone () -		
Annual earned income \$	Annual unearned income \$	Net worth \$	Income and net worth: <input type="checkbox"/> Personal <input type="checkbox"/> Joint		

B. INFORMATION ABOUT THE OWNER (If different from Proposed Insured)

Individual, Trustee or Company Name		Relationship to Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Trustee <input type="checkbox"/> Other:			
If Trust, list Trust Name and Trust Date					
Mailing Address*		City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip	Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY)	E-Mail		Personal Phone () -	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower		U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	
Owner's or Trustee's personal Driver's License or other government issued photo ID, or corporate license:					
Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /	



B. INFORMATION ABOUT THE OWNER (continued)**Contingent Owner** (If none specified, policy provisions will apply)

Individual, Trustee or Company Name		Relationship to Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Trustee <input type="checkbox"/> Other:		
If Trust, list Trust Name and Trust Date				
Mailing Address*		City	State	Zip Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail		Personal Phone () -
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Contingent Owner's or Trustee's personal Driver's License or other government issued photo ID, or corporate license:				
Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /

*Mail notices to: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other		Name and relationship to Owner		
Other Notice Mailing Address	City	State	Zip	Personal Phone () -
Past Due Premium/Lapse Notification: You may select an additional person to receive past due premium & possible lapse in coverage notifications.		Name and relationship to Owner		
Notice Mailing Address	City	State	Zip	Personal Phone () -

C. BENEFICIARY DESIGNATION (Attach separate sheet if necessary, signed and dated by the Owner)

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage %
Address	City	State	Zip	Country	
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	Birth State			
Personal Phone () -	Business Phone () -	E-Mail			
Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage %
Address	City	State	Zip	Country	
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	Birth State			
Personal Phone () -	Business Phone () -	E-Mail			



C. BENEFICIARY DESIGNATION (Attach separate sheet if necessary, signed and dated by the Owner) (continued)

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage %
Address		City	State	Zip	Country
Social Security or Tax ID Number		Date of Birth (MM/DD/YY) / /		Birth State	
Personal Phone () -		Business Phone () -		E-Mail	

D. POLICY INFORMATIONProposed Insured: ☐ Tobacco ☐ Non-Tobacco[Tax-Qualification Status: ☐ Qualified ☐ Non-Qualified]

Base Plan		Amount of Insurance \$
[Optional Coverage Riders [Primary Insured Rider [Additional Insured Rider] or [Child Rider]		
Additional Coverage		Amount of Insurance \$
Additional Coverage		Amount of Insurance \$
[Riders That May Be Available on Universal Life Insurance		
<input type="checkbox"/> [Accelerated Access]	<input type="checkbox"/> [Accidental Death Benefit: Amount of Insurance: \$]	
<input type="checkbox"/> [Wellness]	<input type="checkbox"/> [Guaranteed Purchase Option: Option Amount: \$]	
<input type="checkbox"/> [Life Protector]	<input type="checkbox"/> [Waiver of Specified Premium: Waiver Amount: \$]	
<input type="checkbox"/> [Waiver of Monthly Deduction]	<input type="checkbox"/> Other - Details:	
<input type="checkbox"/> [No Lapse Guarantee]	<input type="checkbox"/> Other - Details:	
[Riders That May Be Available on Term Life Insurance		
<input type="checkbox"/> [Waiver of Premium]	<input type="checkbox"/> [Accidental Death Benefit: Amount of Insurance: \$]	
<input type="checkbox"/> [Waiver of Premium Plus]	<input type="checkbox"/> Other - Details:	
[Universal Life Death Benefit Option		
<input type="checkbox"/> Death Benefit Option 1: Level <input type="checkbox"/> Death Benefit Option 2: Increasing <input type="checkbox"/> [Death Benefit Return of Premium Rider]		
[Levelized Strategy Transfer: <input type="checkbox"/> Yes <input type="checkbox"/> No]		
Purpose of Insurance: <input type="checkbox"/> Business Insurance <input type="checkbox"/> Estate Planning <input type="checkbox"/> Income Replacement <input type="checkbox"/> Other _____		
Optional Policy Date (Backdate to save age or future date) (MM/DD/YY): / /		

E. PREMIUM INFORMATION

1. Planned Premium \$	Additional Premium (Lump Sum) \$
Billing Frequency: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Electronic Funds Transfer (EFT – complete authorization)	
<input type="checkbox"/> Other: Government Allotment, Group Bill, Group Bill #	
Has the premium for the policy applied for been given to the Agent/Producer? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount: \$	



E. PREMIUM INFORMATION (continued)

Source of Premium: ☐ 1035 Exchange (approximate amount) \$
☐ Income
☐ Liquidation of other assets (if yes, explain below)
☐ Other (if yes, explain below)

Explanation

2. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than an insured, their family or employer? ☐ Yes ☐ No
(If yes, please attach Premium Financing disclosure forms)

F. INSURANCE HISTORY

(If yes to questions F.1-F.3, please explain in chart below and attach separate sheet if necessary, signed and dated by Proposed Insured)

1. Are any life insurance policy(ies) or annuity contract(s) inforce? ☐ Yes ☐ No
2. Will any life insurance policy(ies) or annuity contract(s) presently or recently inforce be replaced or changed by this policy applied for? ☐ Yes ☐ No
3. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? ☐ Yes ☐ No

Inforce or Applied For	Company	Being Replaced	Death Benefit	Waiver of Premium	Personal/Business	Year Issued
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? (If yes, please explain below) ☐ Yes ☐ No

Explanation

G. OTHER NON-MEDICAL INFORMATION

1. a. Do you use any form of tobacco or nicotine based products? ☐ Yes ☐ No
b. If no, have you used any form of tobacco or nicotine based products in the last 5 years? ☐ Yes ☐ No
c. If yes, when did you last use tobacco or nicotine based products?

Mo./Yr. Last Used: Type: Quantity:

2. Have you ever engaged or intend within the next 2 years to engage in:
a. Any aviation activity other than as a passenger? ☐ Yes ☐ No
b. Ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? ☐ Yes ☐ No
3. In the last 5 years, have you had a personal or business bankruptcy; or do you currently have any civil lawsuits or judgments pending against you? ☐ Yes ☐ No
4. Have you ever had your driver's license suspended or revoked; or ever plead guilty to or been convicted of driving while under the influence of alcohol or drugs? ☐ Yes ☐ No
5. In the last 5 years, have you plead guilty to or been convicted of a moving violation or been involved in an accident in which you were at fault? ☐ Yes ☐ No
6. In the last 10 years, have you been arrested, convicted, or imprisoned for any crime; or do you currently have any criminal charges pending against you? ☐ Yes ☐ No



G. OTHER NON-MEDICAL INFORMATION (continued)

7. Are you or the owner a member of the Armed Forces or an active or reserve military unit or have either of you entered into a written agreement to become a member of the Armed Forces? ☐ Yes ☐ No
8. Do you intend to travel within the next 2 years outside the United States or Canada? ☐ Yes ☐ No
9. Have you or the owner established a residence outside the U.S. or Canada within the last 2 years or intend to establish a residence outside the U.S. or Canada within the next 2 years? ☐ Yes ☐ No
10. In the last 5 years, have you been the insured or annuitant on a life insurance policy or annuity contract that was sold to a life settlement/viatical company, secondary market purchaser or an investor? ☐ Yes ☐ No
11. Will any person or entity, other than a life insurance company, evaluate you in order to provide any form of life expectancy evaluation? ☐ Yes ☐ No
12. Have you, the owner, the beneficiary or anyone on your behalf discussed or arranged for the sale or assignment of this policy or any beneficial interest in an entity that owns this policy? ☐ Yes ☐ No
13. Will you, the owner or beneficiary receive a fee, rebate or any form of compensation if this policy is issued? . . . ☐ Yes ☐ No

Provide complete details of any yes answers to questions G.1 through G.13. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question #	Details

H. MEDICAL PROFESSIONAL CONTACT INFORMATION

(Attach separate sheet if necessary, signed and dated by Proposed Insured)

1. Contact information for your medical professional(s) or health care provider(s):

Name and Title	Address	Phone Number

2. When did you last consult a medical professional? What was the diagnosis and follow-up treatment?

--

3. Are you currently taking prescribed or over-the-counter medications? If yes, please list below.. . . . ☐ Yes ☐ No

--

I. MEDICAL INFORMATION

For Proposed Insured, this section does not need to be completed if an Aviva company medical exam is required. Please skip to Section J if it is not necessary to complete Section I.

1.

Height in shoes	ft.	in.	Weight in clothes	lbs.
-----------------	-----	-----	-------------------	------
2. Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No
3. Are you now under observation or treatment by a medical professional? ☐ Yes ☐ No
4. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? ☐ Yes ☐ No
5. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? ☐ Yes ☐ No
6. Have you ever been diagnosed, tested positive for, been treated for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No



I. MEDICAL INFORMATION (continued)

- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? . . . ☐ Yes ☐ No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? . . . ☐ Yes ☐ No
- d. Diabetes, thyroid, glandular or endocrinal disorder? . . . ☐ Yes ☐ No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? . . . ☐ Yes ☐ No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease or cirrhosis? . . . ☐ Yes ☐ No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? . . . ☐ Yes ☐ No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? . . . ☐ Yes ☐ No
- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? . . . ☐ Yes ☐ No
- j. Anemia, hepatitis, or any blood disorder? . . . ☐ Yes ☐ No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? . . . ☐ Yes ☐ No
7. Within the last 5 years, have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? . . . ☐ Yes ☐ No
8. Within the last 5 years, other than noted in previous questions, have you:
- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? . . . ☐ Yes ☐ No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? . . . ☐ Yes ☐ No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? . . . ☐ Yes ☐ No
9. Within the last 5 years, have you been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? . . . ☐ Yes ☐ No
10. Do you currently use alcoholic beverages? . . . ☐ Yes ☐ No

If yes, what is the average number of drinks per day?

11. Are you pregnant? . . . ☐ Yes ☐ No If yes, please provide delivery date: / /
12. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? . . . ☐ Yes ☐ No
13. Family information (biological parents, siblings):

Family Member	Sex	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				



I. MEDICAL INFORMATION (continued)

Provide complete details of any yes answers to questions I.2 through I.12. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Medical Professional

J. TAXPAYER IDENTIFICATION

Backup Withholding - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to [Aviva Life and Annuity Company] the "Company"; OR
- (2) The Internal Revenue Service (IRS) notifies the Company that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding under 26 U.S.C. § 3406(a)(1)(C); OR
- (4) You fail to certify to the Company that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

To Prevent Backup Withholding

To prevent backup withholding on payments under the policy, provide taxpayer identification numbers where requested in this application. The taxpayer identification number for an individual is their social security number. The taxpayer identification number for a corporation is their employer identification number. In addition to providing taxpayer identification numbers, you must certify that you are not subject to backup withholding. To certify that the Proposed Insured and/or the Owner is not subject to backup withholding, read the certification under the Agreements and Representations section below and sign this application.

K. AGREEMENTS AND REPRESENTATIONS

It is hereby represented that I have read the application(s) and all the answers and statements provided in the application(s) and any documents providing supplemental information (the "Supplements"), and the answers and statements on the application(s) and any Supplements are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise, the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is/are living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the Owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in this certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

L. IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT ACT, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all Owners as may be required by law.**



M. SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, and "Important Information About the USA Patriot Act" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured and the Authorization and Acknowledgement.

I understand, acknowledge and agree that the Agent/Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent/Producer has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent/Producer has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

I have not been involved with and I am not aware of: (1) any planned sale or assignment of this policy to a life settlement or viatical company, secondary market purchaser or investor; (2) any planned sale or assignment of any interest in a trust or entity that shall own or have an interest in this policy; or (3) any offer of money, future payments, "free insurance" or anything of value to any Owner, Proposed Insured or Beneficiary in connection with this application or policy.

I understand the Company and its affiliates, agents and independent contractors may listen to or record telephone calls between me and its representatives without additional notice to me.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

[Residents of DC: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

Signature of Proposed Insured (or signature of Insured's Personal Representative*)		
X		
Signed at: City	State	Date Signed / /
Signature of Owner if other than the Proposed Insured	Signature of Licensed Agent/Producer	
X	X	
If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign		
Signature of Authorized Signer	Title of Authorized Signer	
X		
*If you are signing on behalf of the Proposed Insured, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured.		
<input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Assignee		
Signature	Printed Name	Date Signed / /
X		



Joint Life Insurance Application

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway
West Des Moines, IA 50266-3862]
Life Customer Contact Center – Tel [800 800 9882] Fax [800 531 0038]

AGENT NAME/PRODUCER CODE:

A. INFORMATION ABOUT PROPOSED INSURED

PROPOSED INSURED #1				PROPOSED INSURED #2			
Is the Proposed Insured Also the Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is the Proposed Insured Also the Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No			
First Name & Middle Initial		Last Name & Suffix		First Name & Middle Initial		Last Name & Suffix	
Mailing Address*				Mailing Address*			
City		State	Zip	City		State	Zip
Street Address (Required if mailing address is PO Box)				Street Address (Required if mailing address is PO Box)			
City		State	Zip	City		State	Zip
Social Security Number		Email		Social Security Number		Email	
Date of Birth	Birth State	Personal Phone () -		Date of Birth	Birth State	Personal Phone () -	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Maiden Name	Business Phone () -		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Maiden Name	Business Phone () -	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower				Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower			
U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a resident or citizen of a country other than the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Visa		Are you a resident or citizen of a country other than the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Visa	
Country of Birth	Country of Residency	Length of time in U.S.		Country of Birth	Country of Residency	Length of time in U.S.	
Driver's License or other government issued photo ID:				Driver's License or other government issued photo ID:			
Document Type		Document Number		Document Type		Document Number	
Where Issued		Issue Date	Expiration Date	Where Issued		Issue Date	Expiration Date
Employer Name		Employer Phone		Employer Name		Employer Phone	
Employer Address				Employer Address			
Occupation/Duties		Length of time at current employer		Occupation/Duties		Length of time at current employer	
Annual earned income \$		Annual unearned income \$		Annual earned income \$		Annual unearned income \$	
Net worth \$		Income and Net Worth: <input type="checkbox"/> Personal <input type="checkbox"/> Joint		Net worth \$		Income and Net Worth: <input type="checkbox"/> Personal <input type="checkbox"/> Joint	



* 1 8 4 5 8 0 6 1 3 0 1 *

B. INFORMATION ABOUT THE OWNER (If different from both Proposed Insured #1 & #2)

Individual, Trustee or Company Name		Relationship to Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Trustee <input type="checkbox"/> Other:		
If Trust, list Trust Name and Trust Date				
Mailing Address*		City	State	Zip Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail		Personal Phone () -
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower		U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Owner's or Trustee's personal Driver's License or other government issued photo ID, or corporate license:				
Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /

Contingent Owner (If none specified, policy provisions will apply)

Individual, Trustee or Company Name		Relationship to Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Trustee <input type="checkbox"/> Other:		
If Trust, list Trust Name and Trust Date				
Mailing Address*		City	State	Zip Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail		Personal Phone () -
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Widow or Widower		U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Resident <input type="checkbox"/> Yes <input type="checkbox"/> No
Contingent Owner's or Trustee's personal Driver's License or other government issued photo ID, or corporate license:				
Document Type	Document Number	Where Issued	Issue Date / /	Expiration Date / /

*Mail notices to: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other		Name and relationship to Owner		
Other Notice Mailing Address	City	State	Zip	Personal Phone () -
Past Due Premium/Lapse Notification: You may select an additional person to receive past due premium & possible lapse in coverage notifications.		Name and relationship to Owner		
Notice Mailing Address	City	State	Zip	Personal Phone () -

C. BENEFICIARY DESIGNATION (Attach separate sheet if necessary, signed and dated by the Owner)

Individual, Trust or Company Name	Relationship to Insured	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage %
Address	City	State	Zip Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	Birth State	
Personal Phone () -	Business Phone () -	E-Mail	



C. BENEFICIARY DESIGNATION (continued)

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage %
Address	City	State	Zip	Country	
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /		Birth State		
Personal Phone () -	Business Phone () -		E-Mail		

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Percentage %
Address	City	State	Zip	Country	
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /		Birth State		
Personal Phone () -	Business Phone () -		E-Mail		

D. POLICY INFORMATION

PROPOSED INSURED #1: ☐ Tobacco ☐ Non-Tobacco **PROPOSED INSURED #2:** ☐ Tobacco ☐ Non-Tobacco

[**Tax Qualification Status:** ☐ Qualified ☐ Non-Qualified]

Base Plan	Amount of Insurance \$
[Optional Coverage Rider(s) Joint Term Rider]	
Additional Coverage	Amount of Insurance \$

[**Riders That May Be Available**]

<input type="checkbox"/> [Estate Protection]	<input type="checkbox"/> [No Lapse Guarantee]
<input type="checkbox"/> [Life Protector]	<input type="checkbox"/> Other - Details:
<input type="checkbox"/> [Policy Split Option]	<input type="checkbox"/> Other - Details:
<input type="checkbox"/> [First Survivor Premium Rider: Initial Face Amount \$ Rider Duration:]	

[**If [First Survivor Premium Rider] Beneficiary Designation is different from Owner, please specify:**]

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Rider	Percentage %
Address	City	State	Zip	Country	
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /		Birth State		
Personal Phone () -	Business Phone () -		E-Mail		

[**Universal Life Death Benefit Option**]

☐ Death Benefit Option 1: Level ☐ Death Benefit Option 2: Increasing ☐ [Death Benefit Return of Premium Rider]

[Levelized Strategy Transfer: ☐ Yes ☐ No]

Purpose of Insurance: ☐ Business Insurance ☐ Estate Planning ☐ Income Replacement ☐ Other _____

Policy Date (optional – backdate to save age or future date) (MM/DD/YY): / /



E. PREMIUM INFORMATION

1. Planned Premium \$	Additional Premium (Lump Sum) \$
--------------------------	-------------------------------------

Billing Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Electronic Funds Transfer (EFT—complete authorization)
☐ Other: Government Allotment, Group Bill, Group Bill #

Has the premium for the policy applied for been given to the Agent/Producer? ☐ Yes ☐ No Amount: \$

Source of Premium: ☐ 1035 Exchange. (approximate amount) \$
☐ Earned Income
☐ Liquidation of other assets (If yes, explain below)
☐ Other (If yes, explain below)

Explanation

2. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than an insured, their family or employer? ☐ Yes ☐ No
(If yes, please attach Premium Financing disclosure forms)

F. INSURANCE HISTORY

	PROPOSED INSURED #1	PROPOSED INSURED #2
1. Are any life insurance policy(ies) or annuity contract(s) inforce?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Will any life insurance policy(ies) or annuity contract(s) presently or recently inforce be replaced or changed by this policy applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(If yes to questions F.1-F.3, please explain in chart below)

Proposed Insured #1 (Attach separate sheet if necessary, signed and dated by Proposed Insured #1)

Inforce or Applied For	Company	Being Replaced	Death Benefit	Waiver of Premium	Personal/Business	Year Issued

Proposed Insured #2 (Attach separate sheet if necessary, signed and dated by Proposed Insured #2)

Inforce or Applied For	Company	Being Replaced	Death Benefit	Waiver of Premium	Personal/Business	Year Issued

4. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? ☐ Yes ☐ No ☐ Yes ☐ No
(If yes, please explain below)

PROPOSED INSURED #1	PROPOSED INSURED #2



G. OTHER NON-MEDICAL INFORMATION

- | | PROPOSED
INSURED #1 | PROPOSED
INSURED #2 |
|--|--|--|
| 1. Do you use any form of tobacco or nicotine based products? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If no, have you used any form of tobacco or nicotine based products in the last 5 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, when did you last use tobacco or nicotine based products? | | |
| PROPOSED INSURED #1 | | |
| Mo./Yr. Last Used: <input style="width: 150px;" type="text"/> | Type: <input style="width: 100px;" type="text"/> | Quantity: <input style="width: 100px;" type="text"/> |
| PROPOSED INSURED #2 | | |
| Mo./Yr. Last Used: <input style="width: 150px;" type="text"/> | Type: <input style="width: 100px;" type="text"/> | Quantity: <input style="width: 100px;" type="text"/> |
| 2. Have you engaged or intend within the next 2 years to engage in: | | |
| a. Any aviation activity other than as a passenger? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. In the last 5 years, have you had a personal or business bankruptcy; or do you currently have any civil lawsuits or judgments pending against you? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever had your driver's license suspended or revoked; or ever plead guilty to or been convicted of driving while under the influence of alcohol or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. In the last 5 years, have you plead guilty to or been convicted of a moving violation or been involved in an accident in which you were at fault? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. In the last 10 years, have you been arrested, convicted, or imprisoned for any crime; or do you currently have any criminal charges pending against you? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Are you or the owner a member of the Armed Forces or an active or reserve military unit or have either of you entered into a written agreement to become a member of the Armed Forces? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you intend to travel within the next 2 years outside the United States or Canada? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you or the owner established a residence outside the U.S. or Canada within the last 2 years or intend to establish a residence outside the U.S. or Canada within the next 2 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. In the last 5 years, have you been the insured or annuitant on a life insurance policy or annuity contract that was sold to a life settlement/viatical company, secondary market purchaser or an investor? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Will any person or entity, other than a life insurance company, evaluate you in order to provide any form of life expectancy evaluation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Have you, the owner, the beneficiary or anyone on your behalf discussed or arranged for the sale or assignment of this policy or any beneficial interest in an entity that owns this policy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Will you, the owner or beneficiary receive a fee, rebate or any form of compensation if this policy is issued? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Provide complete details of any yes answers to questions G.1-G.13. (Attach separate sheet if necessary, signed and dated by Proposed Insureds #1 & #2)

Ques. #	PROPOSED INSURED #1	Ques. #	PROPOSED INSURED #2



H. MEDICAL PROFESSIONAL CONTACT INFORMATION

(Attach separate sheet if necessary, signed and dated by Proposed Insureds #1 & #2)

1. Contact information for your medical professional(s) or health care provider(s):

	Name & Title	Address	Phone Number
PROPOSED INSURED #1			
PROPOSED INSURED #2			

2. When did you last consult a medical professional? What was the diagnosis and follow-up treatment?

PROPOSED INSURED #1	
PROPOSED INSURED #2	

3. Are you currently taking prescribed or over-the-counter medications? (If yes, please list below)

PROPOSED INSURED #1	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PROPOSED INSURED #2	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I. MEDICAL INFORMATION

For each Proposed Insured, this section does not need to be completed if an Aviva company medical exam is required for that Proposed Insured. Please skip to Section J if it is not necessary to complete Section I.

1. PROPOSED INSURED #1

PROPOSED INSURED #2

Height in shoes	Weight in clothes
ft. in.	lbs.

Height in shoes	Weight in clothes
ft. in.	lbs.

PROPOSED
INSURED #1

PROPOSED
INSURED #2

- | | | |
|--|--|--|
| 2. Have you gained or lost more than 10 pounds in the last year? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are you now under observation or treatment by a medical professional? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever been diagnosed by a medical professional as having or been treated for
AIDS or ARC (AIDS-related complex)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic
(HIV) virus? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you ever been diagnosed, tested positive for, been treated for, or been given medical
advice by a member of the medical profession for a disease or disorder such as: | | |
| a. Disease of the heart or circulatory system, including high blood pressure, heart attack,
coronary artery disease, or chest pain? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise
treadmill test? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Diabetes, thyroid, glandular or endocrinal disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia,
shortness of breath, or abnormal chest x-ray? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis,
Crohn's disease or cirrhosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted
diseases, sugar, albumin or blood in urine? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy,
chronic headaches, memory changes or fainting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or
nervous system disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Anemia, hepatitis, or any blood disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |



* 1 8 4 5 8 0 6 1 3 0 6 *

I. MEDICAL INFORMATION (continued)

7. Within the last 5 years, have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No ☐ Yes ☐ No
8. Within the last 5 years, other than noted in previous questions, have you:
- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? ☐ Yes ☐ No ☐ Yes ☐ No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? ☐ Yes ☐ No ☐ Yes ☐ No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No ☐ Yes ☐ No
9. Within the last 5 years, have you been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? ☐ Yes ☐ No ☐ Yes ☐ No
10. Do you currently use alcoholic beverages? ☐ Yes ☐ No ☐ Yes ☐ No
If yes, what is the average number of drinks per day?

PROPOSED INSURED #1:

PROPOSED INSURED #2:

11. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No ☐ Yes ☐ No
12. Family information (biological parents, siblings):

PROPOSED INSURED #1:

Family Member	Sex	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				

PROPOSED INSURED #2:

Family Member	Sex	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				



* 1 8 4 5 8 0 6 1 3 0 7 *

I. MEDICAL INFORMATION (continued)

Provide complete details of any yes answers to questions I.2-I.11. (Attach separate sheet if necessary, signed and dated by Proposed Insureds #1 & #2)

	Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility
PROPOSED INSURED #1				
PROPOSED INSURED #2				

J. TAXPAYER IDENTIFICATION

Backup Withholding - You are subject to backup withholding if:

- (1) You fail to furnish your taxpayer identification number to [Aviva Life and Annuity Company] (the "Company"); OR
- (2) The Internal Revenue Service (IRS) notifies the Company that you furnished an incorrect taxpayer identification number; OR
- (3) You are notified that you are subject to backup withholding under 26 U.S.C. § 3406(a)(1)(C); OR
- (4) You fail to certify to the Company that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

To Prevent Backup Withholding

To prevent backup withholding on payments under the policy, provide taxpayer identification numbers where requested in this application. The taxpayer identification number for an individual is their social security number. The taxpayer identification number for a corporation is their employer identification number. In addition to providing taxpayer identification numbers, you must certify that you are not subject to backup withholding. To certify that the Proposed Insureds and/or the Owner is not subject to backup withholding, read the certification under the Agreements and Representations section below and sign this application.

K. AGREEMENTS AND REPRESENTATIONS

It is hereby represented that I have read the application(s) and all the answers and statements provided in the application(s) and any documents providing supplemental information (the "Supplements"), and the answers and statements on the application(s) and any Supplements are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Joint Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise, the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insureds are living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 or page 2, if applicable, of this application for me as the Owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in this certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.



* 1 8 4 5 8 0 6 1 3 0 8 *

L. IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT ACT, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all Owners as may be required by law.**

M. SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, and "Important Information About the USA Patriot Act" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured and the Authorization and Acknowledgement.

I understand, acknowledge and agree that the Agent/Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent/Producer has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent/Producer has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

I have not been involved with and I am not aware of: (1) any planned sale or assignment of this policy to a life settlement or viatical company, secondary market purchaser or investor; (2) any planned sale or assignment of any interest in a trust or entity that shall own or have an interest in this policy; or (3) any offer of money, future payments, "free insurance" or anything of value to any Owner, Proposed Insured or Beneficiary in connection with this application or policy.

I understand the Company and its affiliates, agents and independent contractors may listen to or record telephone calls between me and its representatives without additional notice to me.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

[**Residents of DC:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

Location Signed:		Signature of Owner/Proposed Insured #1 (or signature of Insured's Personal Representative*)
City	State	X
On (date)		Signature of Owner/Proposed Insured #2 (or signature of Insured's Personal Representative*)
		X
Signature of Owner if other than the Proposed Insured		Signature of Licensed Agent/Producer
X		X
If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign		
Signature of Authorized Signer		Title of Authorized Signer
X		
*If you are signing on behalf of the Proposed Insured(s), print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured(s).		
<input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Assignee		
Signature	Printed Name	Date Signed
X		/ /



Term Conversion Application

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway

West Des Moines, IA 50266-3862]

Life Customer Contact Center – Tel [800 800 9882] Fax [800 531 0038]

AGENT/PRODUCER CODE & NAME:

INSTRUCTIONS

- When requesting a face amount increase, the Proposed Insured must complete and attach a Policy Change Application.
- When converting two life insurance policies to one joint life policy, each Proposed Insured must complete a Term Conversion Application.

Policy Number	Amount to be Converted \$	Amount to Retain in Existing Policy \$
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A. INFORMATION ABOUT THE PROPOSED INSURED

First Name	M. I.	Last Name	Suffix	Is Proposed Insured also the Owner? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address*		City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip	Country
Social Security Number	Date of Birth (MM/DD/YY) / /		Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Personal Phone () -	Business Phone () -	E-Mail			

B. INFORMATION ABOUT THE OWNER (If different from Proposed Insured)

Individual, Trustee or Company Name			Relationship to Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Trustee <input type="checkbox"/> Other:		
If Trust, list Trust Name and Trust Date			Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Mailing Address*		City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip	Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail			Personal Phone () -

Contingent Owner (If none specified, policy provisions will apply)

Individual, Trustee or Company Name			Relationship to Proposed Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Trustee <input type="checkbox"/> Other:		
If Trust, list Trust Name and Trust Date			Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Mailing Address*		City	State	Zip	Country
Street Address: (Required if mailing address is a PO Box)		City	State	Zip	Country
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /	E-Mail			Personal Phone () -



*Mail notices to: <input type="checkbox"/> Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other				Name and relationship to Owner	
Other Notice Mailing Address	City	State	Zip	Personal Phone () -	
Past Due Premium/Lapse Notification: You may select an additional person to receive past due premium & possible lapse in coverage notifications.				Name and relationship to Owner	
Notice Mailing Address	City	State	Zip	Personal Phone () -	

C. BENEFICIARY DESIGNATION* (Attach separate sheet if necessary, signed and dated by the Owner)

*If Beneficiary Designation section is not completed, the beneficiary(ies) from original policy will be used.

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent		Percentage %
Address	City	State	Zip	Country		
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /		Birth State			
Personal Phone () -	Business Phone () -		E-Mail			

Individual, Trust or Company Name		Relationship to Insured		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent		Percentage %
Address	City	State	Zip	Country		
Social Security or Tax ID Number	Date of Birth (MM/DD/YY) / /		Birth State			
Personal Phone () -	Business Phone () -		E-Mail			

D. POLICY INFORMATION

Proposed Insured: ☐ Tobacco ☐ Non-Tobacco

[Tax-Qualification Status: ☐ Qualified ☐ Non-Qualified]

Base Plan	Amount of Insurance (Total Death Benefit) \$
------------------	---

[Riders (Will require insurability if not on original policy)

If the Total Death Benefit converted exceeds the convertible amount allowed, or a rider is added, an Application for Policy Change with Evidence of Insurability must be completed.

[Universal Life Death Benefit Option 1: Level

[Levelized Strategy Transfer: ☐ Yes ☐ No]

Policy Date (optional – backdate to save age or future date) (MM/DD/YY): / /



* 1 8 4 6 5 0 6 1 3 0 2 *

E. PREMIUM INFORMATION

1. Planned Premium \$	Additional Premium (Lump Sum) \$
--------------------------	-------------------------------------

Billing Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Electronic Funds Transfer (EFT – complete authorization)
☐ Add to existing Bank Authorization

☐ Other: Government Allotment, Group Bill, Group Bill #

Has the premium for the policy applied for been given to the Agent/Producer? ☐ Yes ☐ No Amount: \$

2. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than an insured, their family or employer? ☐ Yes ☐ No
(If yes, please attach Premium Financing disclosure forms)

3. Will you, the owner or beneficiary receive a fee, rebate or any form of compensation if this policy is issued? . . ☐ Yes ☐ No

F. OTHER NON-MEDICAL INFORMATION

1. Have you used any form of tobacco or nicotine based product within the last 12 months? ☐ Yes ☐ No
(This question is only required if you were under 18 when you purchased your insurance. Your answer can only be used to provide you with a better rate class.)

G. AGREEMENTS AND REPRESENTATIONS

I hereby represent, agree and understand all of the following:

That if the term life insurance policy is not yet incontestable, as determined by the incontestability provisions of the term life insurance policy, then the new policy will be subject to the same incontestability provisions, based on the date of the term life insurance policy.

That the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. I agree and understand that information not recorded on the application(s) and any Supplements will not be treated as known to [Aviva Life and Annuity Company] (the "Company"). A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract, notwithstanding any contestable and/or incontestable provisions of the term life insurance policy. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.

The new policy will take effect and coverage will begin when all the requirements of the conversion provisions under the term life insurance policy have been met, including any required settlement for the new policy. I understand if I have elected to retain any of the term insurance as part of this conversion application, then I must continue to pay the corresponding term life insurance premiums that will be separate from any premiums required for the converted insurance.

H. IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT ACT, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all Owners as may be required by law.**



I. SIGNATURES

I have reviewed and understand the information contained above in the "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, and "Important Information About the USA Patriot Act" sections.

I understand, acknowledge and agree that the Agent/Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent/Producer has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent/Producer has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

I have not been involved with and I am not aware of: (1) any planned sale or assignment of this policy to a life settlement or viatical company, secondary market purchaser or investor; (2) any planned sale or assignment of any interest in a trust or entity that shall own or have an interest in this policy; or (3) any offer of money, future payments, "free insurance" or anything of value to any Owner, Proposed Insured or Beneficiary in connection with this application or policy.

I understand the Company and its affiliates, agents and independent contractors may listen to or record telephone calls between me and its representatives without additional notice to me.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

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Signature of Proposed Insured (or signature of Insured's Personal Representative*) X		
Signed at: City	State	Date Signed / /
Signature of Owner if other than the Proposed Insured X	Signature of Licensed Agent/Producer X	
If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign		
Signature of Authorized Signer X	Title of Authorized Signer	
*If you are signing on behalf of the Proposed Insured, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured.		
<input type="checkbox"/> Conservator <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Assignee		
Signature X	Printed Name	Date Signed / /



* 1 8 4 6 5 0 6 1 3 0 4

Supplemental Application

[www.avivausa.com]



[Aviva Life and Annuity Company]

7700 Mills Civic Parkway
West Des Moines, IA 50266-3862
Life Customer Contact Center – Tel:[800 800 9882] Fax:[800 531 0038]

AGENT/PRODUCER CODE & NAME:

To be made a part of a life insurance policy applied for or now in force on the life of

Policy # (if known)

☐ Additional Insured Rider Amount ☐ Tobacco ☐ Non-Tobacco ☐ Family ☐ Non-Family

☐ Children's Insurance Rider Amount

A. INFORMATION ABOUT THE PROPOSED INSURED(S)

1. Proposed Insured(s)

Full Name	Relationship	Age	Birth Date	Birth State	Sex	Height	Weight	Occupation	Amount of Life Insurance Inforce Including Accidental Death Benefit

If there are additional children to be covered, check here ☐ and complete a second Supplemental Application.
(The beneficiary for the additional Proposed Insured(s) and covered children will be the policy's Insured)

B. INSURANCE HISTORY

(If yes to questions B.1-B.3, please explain in chart below and attach separate sheet if necessary, signed and dated by Proposed Insured(s))

- Are any life insurance policy(ies) or annuity contract(s) inforce? ☐ Yes ☐ No
- Will any life insurance policy(ies) or annuity contract(s) presently or recently inforce be replaced or changed by this policy applied for? ☐ Yes ☐ No
- Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? ☐ Yes ☐ No

Inforce or Applied For	Company	Being Replaced	Death Benefit	Waiver of Premium	Personal/Business	Year Issued

- Has any Proposed Insured ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? (If yes, please explain below) ☐ Yes ☐ No

Explanation



C. OTHER NON-MEDICAL INFORMATION

1. a. Does any Proposed Insured use any form of tobacco or nicotine based products? ☐ Yes ☐ No
b. If no, has any Proposed Insured used any form of tobacco or nicotine based products in the last 5 years? ☐ Yes ☐ No
c. If yes, when did any Proposed Insured last use tobacco or nicotine based products?
Mo./Yr. Last Used: Type: Quantity:
2. Has any Proposed Insured ever engaged or intend within the next 2 years to engage in:
a. Any aviation activity other than as a passenger? ☐ Yes ☐ No
b. Ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving,
underwater diving or any other hazardous sport or activity? ☐ Yes ☐ No
3. In the last 5 years, has any Proposed Insured had a personal or business bankruptcy; or does he or she
currently have any civil lawsuits or judgments pending against them? ☐ Yes ☐ No
4. Has any Proposed Insured ever had their driver's license suspended or revoked; or ever plead guilty to or
been convicted of driving while under the influence of alcohol or drugs? ☐ Yes ☐ No
5. In the last 5 years, has any Proposed Insured plead guilty to or been convicted of a moving violation or been
involved in an accident in which they were at fault? ☐ Yes ☐ No
6. In the last 10 years, has any Proposed Insured been arrested, convicted, or imprisoned for any crime; or does
he or she currently have any criminal charges pending against them? ☐ Yes ☐ No
7. Is any Proposed Insured or the owner a member of the Armed Forces or an active or reserve military unit or
have either of them entered into a written agreement to become a member of the Armed Forces? ☐ Yes ☐ No
8. Does any Proposed Insured intend to travel within the next 2 years outside the United States or Canada? ☐ Yes ☐ No
9. Has any Proposed Insured or the owner established a residence outside the U.S. or Canada within the last 2
years or intend to establish a residence outside the U.S. or Canada within the next 2 years? ☐ Yes ☐ No
10. In the last 5 years, has any Proposed Insured been the insured or annuitant on a life insurance policy or annuity
contract that was sold to a life settlement/viatical company, secondary market purchaser or an investor? ☐ Yes ☐ No
11. Will any person or entity, other than a life insurance company, evaluate the applicant(s) in order to provide any
form of life expectancy evaluation? ☐ Yes ☐ No
12. Has any Proposed Insured, the owner, the beneficiary or anyone on their behalf discussed or arranged for the
sale or assignment of this policy or any beneficial interest in an entity that owns this policy? ☐ Yes ☐ No
13. Will any Proposed Insured, the owner or beneficiary receive a fee, rebate or any form of compensation if this
policy is issued? ☐ Yes ☐ No

Provide complete details of any yes answers to questions C.1-C.13. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question #	Proposed Insured	Details

D. MEDICAL INFORMATION

For Proposed Insured, this section does not need to be completed if an Aviva company medical exam is required. Please skip to Section E, if it is not necessary to complete Section D.

1. Has any Proposed Insured gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No
2. Is any Proposed Insured now under observation or treatment by a medical professional? ☐ Yes ☐ No
3. Has any Proposed Insured ever been diagnosed by a medical professional as having or been treated for AIDS
or ARC (AIDS-related complex)? ☐ Yes ☐ No
4. Has any Proposed Insured ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV)
virus? ☐ Yes ☐ No



D. MEDICAL INFORMATION (continued)

5. Has any Proposed Insured ever been diagnosed, tested positive for, been treated for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No
 - b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? ☐ Yes ☐ No
 - c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? ☐ Yes ☐ No
 - d. Diabetes, thyroid, glandular or endocrinal disorder? ☐ Yes ☐ No
 - e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No
 - f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease or cirrhosis? ☐ Yes ☐ No
 - g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ☐ Yes ☐ No
 - h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? ☐ Yes ☐ No
 - i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No
 - j. Anemia, hepatitis, or any blood disorder? ☐ Yes ☐ No
 - k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No
6. Within the last 5 years, has any Proposed Insured ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No
7. Within the last 5 years, other than noted in previous questions, has any Proposed Insured:
- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? ☐ Yes ☐ No
 - b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? ☐ Yes ☐ No
 - c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No
8. Within the last 5 years, has any Proposed Insured been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? ☐ Yes ☐ No
9. Does any Proposed Insured currently use alcoholic beverages? ☐ Yes ☐ No
- If yes, what is the average number of drinks per day?
10. Is any Proposed Insured pregnant? ☐ Yes ☐ No If yes, please provide delivery date: / /
11. Does the Proposed Insured have a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No
12. Family information (biological parents, siblings):

Family Member	Sex	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				



D. MEDICAL INFORMATION (continued)

Provide complete details of any yes answers to questions D.1-D.11. (Attach separate sheet if necessary, signed and dated by the Proposed Insured)

Question #	Proposed Insured	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Medical Professional

E. AGREEMENTS AND REPRESENTATIONS

It is hereby represented that I have read the application(s) and all the answers and statements provided in the application(s) and any documents providing supplemental information (the "Supplements"), and the answers and statements on the application(s) and any Supplements are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to Aviva Life and Annuity Company (the "Company"). A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.



F. SIGNATURES

I have reviewed and understand the information contained above in the "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, and further acknowledge receipt of the Disclosure Notice to Proposed Insured and the Authorization and Acknowledgement.

I understand, acknowledge and agree that the Agent/Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent/Producer has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent/Producer has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

I have not been involved with and I am not aware of: (1) any planned sale or assignment of this policy to a life settlement or viatical company, secondary market purchaser or investor; (2) any planned sale or assignment of any interest in a trust or entity that shall own or have an interest in this policy; or (3) any offer of money, future payments, "free insurance" or anything of value to any Owner, Proposed Insured or Beneficiary in connection with this application or policy.

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I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

[**Residents of DC:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

Signature of Proposed Insured (or signature of Insured's Personal Representative*)

X

Signed at: City

State

Date Signed

/ /

Signature of Owner if other than the Proposed Insured

X

Signature of Licensed Agent/Producer

X

If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign

Signature of Authorized Signer

X

Title of Authorized Signer

*If you are signing on behalf of the Proposed Insured, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature

X

Printed Name

Date Signed

/ /



* 1 8 4 7 2 0 6 1 3 0 5 *

Non-Medical Questionnaire

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway
West Des Moines, IA 50266-3862]
Life Customer Contact Center – Tel [800 800 9882] Fax [800 531 0038]

AGENT/PRODUCER CODE & NAME:

Policy Number	Proposed Insured	Date of Birth (mm/dd/yy) / /
---------------	------------------	---------------------------------

A. MEDICAL PROFESSIONAL CONTACT INFORMATION

(Attach separate sheet if necessary, signed and dated by Proposed Insured)

1. Contact information for your medical professional(s) or health care provider(s):

Name and Title	Address	Phone Number

2. When did you last consult a medical professional? What was the diagnosis and follow-up treatment?

--

3. Are you currently taking prescribed or over-the-counter medications? If yes, please list below. ☐ Yes ☐ No

--

B. MEDICAL INFORMATION

- | | | | | |
|--------------------|-----|-----|-------------------|------|
| 1. Height in shoes | ft. | in. | Weight in clothes | lbs. |
|--------------------|-----|-----|-------------------|------|
2. Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No
3. Are you now under observation or treatment by a medical professional? ☐ Yes ☐ No
4. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? ☐ Yes ☐ No
5. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? ☐ Yes ☐ No
6. Have you ever been diagnosed, tested positive for, been treated for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? . . . ☐ Yes ☐ No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? ☐ Yes ☐ No
- d. Diabetes, thyroid, glandular or endocrinal disorder? ☐ Yes ☐ No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease or cirrhosis? ☐ Yes ☐ No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ☐ Yes ☐ No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? ☐ Yes ☐ No



B. MEDICAL INFORMATION (continued)

- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No
- j. Anemia, hepatitis, or any blood disorder? ☐ Yes ☐ No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No
7. Within the last 5 years, have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No
8. Within the last 5 years, other than noted in previous questions, have you:
- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? . . . ☐ Yes ☐ No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? . . . ☐ Yes ☐ No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No
9. Within the last 5 years, have you been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? ☐ Yes ☐ No
10. Do you currently use alcoholic beverages? ☐ Yes ☐ No
- If yes, what is the average number of drinks per day?
11. Are you pregnant? ☐ Yes ☐ No If yes, please provide delivery date: / /
12. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No
13. Family information (biological parents, siblings):

Family Member	Sex	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				

Provide complete details of any yes answers to questions B.2-B.12. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Medical Professional

C. AGREEMENTS AND REPRESENTATIONS

It is hereby represented that I have read the application(s) and all the answers and statements provided in the application(s) and any documents providing supplemental information (the "Supplements"), and the answers and statements on the application(s) and any Supplements are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to Aviva Life and Annuity Company (the "Company"). A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.



D. SIGNATURES

It is represented that the answers and statements on the application are complete and true and correctly recorded. I agree that a copy of this application shall be a part of the policy.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting organization, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, evaluation, or treatment of me including information about drugs, alcoholism, or mental illness and any other non-medical information of me to give to the Company or its reinsurers or its authorized representatives any such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information.

I agree that this authorization shall be valid for 2 years from the date shown below and that a photographic copy of this authorization shall be as valid as the original.

Signature of Proposed Insured (or signature of Insured's Personal Representative*)

X

Signed at: City

State

Date Signed

/ /

Signature of Owner if other than the Proposed Insured

X

Signature of Licensed Agent/Producer

X

If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign

Signature of Authorized Signer

X

Title of Authorized Signer

*If you are signing on behalf of the Proposed Insured, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature

X

Printed Name

Date Signed

/ /



* 1 8 4 7 9 0 6 1 3 0 3 *

Medical Examination - Part 1

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway
West Des Moines, IA 50266-3862]
Life Customer Contact Center – Tel:[800 800 9882] Fax:[800 531 0038]

AGENT/PRODUCER CODE & NAME:

(In this application, "Company" refers to the insurance company named above)

Name of Proposed Insured	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy) / /
Social Security Number	Name of Agent	

Medical History Recorded By Examiner (Answers are to be completed by Examiner)

A. MEDICAL PROFESSIONAL CONTACT INFORMATION

1. Contact information for your medical professional(s) or health care provider(s):

Name and Title	Address	Phone Number

2. When did you last consult a medical professional? What was the diagnosis and follow-up treatment?

--

3. Are you currently taking prescribed or over-the-counter medications? If yes, please list below... ☐ Yes ☐ No

--

B. MEDICAL INFORMATION

- | | | | | |
|--------------------|-----|-----|-------------------|------|
| 1. Height in shoes | ft. | in. | Weight in clothes | lbs. |
|--------------------|-----|-----|-------------------|------|
2. Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No
3. Are you now under observation or treatment by a medical professional? ☐ Yes ☐ No
4. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? ☐ Yes ☐ No
5. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? ☐ Yes ☐ No
6. Have you ever been diagnosed, tested positive for, been treated for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? ☐ Yes ☐ No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? ☐ Yes ☐ No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? ☐ Yes ☐ No
- d. Diabetes, thyroid, glandular or endocrinal disorder? ☐ Yes ☐ No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease or cirrhosis? ☐ Yes ☐ No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? ☐ Yes ☐ No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? ☐ Yes ☐ No



* 1 8 4 8 6 0 6 1 3 0 1 *

Medical Examination - Part 1

www.avivausa.com



B. MEDICAL INFORMATION (continued)

- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? ☐ Yes ☐ No
- j. Anemia, hepatitis, or any blood disorder? ☐ Yes ☐ No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? ☐ Yes ☐ No
7. Within the last 5 years, have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? ☐ Yes ☐ No
8. Within the last 5 years, other than noted in previous questions, have you:
- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? . . . ☐ Yes ☐ No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? . . . ☐ Yes ☐ No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? ☐ Yes ☐ No
9. Within the last 5 years, have you been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home, or in a care facility? ☐ Yes ☐ No
10. Do you currently use alcoholic beverages? ☐ Yes ☐ No
- If yes, what is the average number of drinks per day?
11. Are you pregnant? ☐ Yes ☐ No If yes, please provide delivery date: / /
12. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? ☐ Yes ☐ No
13. Family information (biological parents, siblings):

Family Member	Sex	Age if Living	Age at Death	Cause of Death Details
Father				
Mother				
Sibling(s)				

Provide complete details of any yes answers to questions B.2-B.12. (Attach separate sheet if necessary, signed and dated by Proposed Insured)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Medical Professional



* 1 8 4 8 6 0 6 1 3 0 2 *

Medical Examination - Part 1

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B. MEDICAL INFORMATION (continued)

14. Do you exercise regularly (aerobic, calisthenic, jogging or running, swimming)? ☐ Yes ☐ No

If yes, describe and state how often:

15. a. Do you use any form of tobacco or nicotine based products? ☐ Yes ☐ No

b. If no, have you used any form of tobacco or nicotine based products in the last 5 years? ☐ Yes ☐ No

c. If yes, when did you last use tobacco or nicotine based products?

Mo./Yr. Last Used: Type: Quantity:

B. SIGNATURES

It is represented that the answers and statements on this application are complete and true and correctly recorded.

I agree that a copy of this application shall be a part of the policy.

I authorize any physician, medical practitioner, hospital, clinic, pharmaceutical database, other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting organization, or employer having information available as to diagnosis, treatment, or prognosis with respect to any physical or mental condition, evaluation, or treatment of me including information about drug use, alcoholism, HIV, or mental illness and any other non-medical information about me to give to [Aviva Life and Annuity Company] (the "Company"), its reinsurers or its authorized representatives any such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I agree that this authorization shall be valid for 2 years from the date shown below and that a photographic copy of this authorization shall be as valid as the original.

Signed/Dated at	Signature of Examiner
City, State	X
On	Signature of Proposed Insured
Date	X



* 1 8 4 8 6 0 6 1 3 0 3 *

A. PHYSICAL EXAMINATION

1.

a. Measured Height (in shoes)	ft.	in.
b. Scale Weight (clothed)	lbs.	
2. Blood Pressure
Arm, sitting - take 2 readings and record both. If a reading is higher than 140/90, record 2 more readings at end of examination.
3. Cardiac
 - a. Pulse

Rate per minute	Describe irregularities and give number per minute
at rest sitting...	

If lowest pulse rate is over 90, record an at-rest rate at end of examination here:
 - b. Heart Findings - Auscultate all valve areas

Any murmur?	Any other irregularity - PVC, clicks or gallup?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If murmur heard, describe in question 4.	Describe:
4. Description of Heart Murmur

a. Location: <input type="checkbox"/> Apical <input type="checkbox"/> Aortic <input type="checkbox"/> Pulmonic: b. Timing: <input type="checkbox"/> Holosystolic <input type="checkbox"/> Midsystolic <input type="checkbox"/> Diastolic c. Character: <input type="checkbox"/> Rough <input type="checkbox"/> Blowing <input type="checkbox"/> Other: _____ Grade: <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6	d. If transmitted, where? e. Does squatting or valsalva maneuver affect the murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Is murmur heard: <input type="checkbox"/> Left Lateral? _____ <input type="checkbox"/> Supine? _____ <input type="checkbox"/> Sitting? _____ <input type="checkbox"/> Standing? _____
g. If more than 1 murmur, describe separately here:	
h. Your diagnosis of murmur(s):	
5. Other Cardiac Findings — Is/are there any:
 - a. Evidence of cyanosis, clubbing, dyspnea, edema or enlargement? ☐ Yes ☐ No
 If enlarged, give location of left border:
 - b. Carotid bruit or absence of pedal pulses? ☐ Yes ☐ No
 - c. Abnormality of veins? ☐ Yes ☐ No
 - d. Any other cardiac abnormality? ☐ Yes ☐ No
 - e. If any above are yes, what is your diagnosis or opinion?



* 1 8 4 8 6 0 6 1 3 0 4 *

Medical Examination - Part 2

www.avivausa.com



A. PHYSICAL EXAMINATION (continued)

6. General Examination — Is there any abnormality of:
- a. Ears or eyes? ☐ Yes ☐ No
 - b. Nose, mouth, throat or lungs? ☐ Yes ☐ No
 - c. Skin, musculoskeletal system or amputations? ☐ Yes ☐ No
 - d. Neurologic system (include paralysis, reflexes)? ☐ Yes ☐ No
 - e. Endocrine or lymphatic systems? ☐ Yes ☐ No

Provide complete details of any yes answers to questions 6.a-6.e in question 9 below.

7. Was an interpreter used to complete this form if the Proposed Insured cannot speak or understand English? ☐ Yes ☐ No

Interpreter name	Relationship of Interpreter
------------------	-----------------------------

8. Miscellaneous Information
- a. Are you aware of any additional medical history or findings? ☐ Yes ☐ No
(A confidential report may be made to the Company's Medical Director or details may be provided in question 9)
 - b. Is appearance that of good health? (If no, describe in question 9). ☐ Yes ☐ No
 - c. Are you related to or have a business association with either the Proposed Insured or the Agent?
(If yes, describe in question 9). ☐ Yes ☐ No
 - d. Are you the Proposed Insured's personal physician? ☐ Yes ☐ No
If yes, for how long? _____ years

9. Additional Medical History and Comments:

10. Blood and Urine Specimens - should be based on the amount of insurance applied for

[\$100,000 — up] Draw blood samples and collect urine specimen using the provided blood kit and send kit (with blood and urine samples) to designated lab.

[\$10,000 — \$99,999] Collect urine specimen and send to designated lab in provided specimen container.

Indicate handling: ☐ Blood and urine sent to lab ☐ EKG tracing attached
☐ Urine only sent to lab

I certify that I have questioned and examined the Proposed Insured.

Proposed Insured's full name	Proposed Insured's Address (City and State)
------------------------------	---

, of

Date of exam	Time of exam	<input type="checkbox"/> AM <input type="checkbox"/> PM	Place of exam
--------------	--------------	--	---------------

Signature of examiner

X

FEE Information. Send fee to:

(please use stamp or print legibly, include taxpayer no.)

Please be sure the Proposed Insured has signed Part 1 and the examiner has signed both Parts 1 and 2.

Please see Company instructions for mailing.

If any additional studies required by the Company were done, indicate what was done and send tracing or film with the exam form.



* 1 8 4 8 6 0 6 1 3 0 5 *

Conditional Life Insurance Agreement

[www.avivausa.com]

**Aviva Life and Annuity Company]**

7700 Mills Civic Parkway

West Des Moines, IA 50266-3862]

Life Customer Contact Center – Tel:[800 800 9882] Fax:[800 531 0038]

AGENT/PRODUCER CODE:

AGENT/PRODUCER NAME:

(In this receipt, "Company" refers to the insurance company named above)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS \$3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
 - a. \$500,000 or the amount in Section D of the application, if the proposed insured is insurable at the rate applied for or better; or
 - b. \$100,000 or the amount in Section D of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from Payment in the Amount of \$

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

Signature of Proposed Insured

X

Signed at: City

State

Date Signed

/ /

Signature of Owner if other than the Proposed Insured

X

Signature of Licensed Agent/Producer

X

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK



Conditional Life Insurance Agreement

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway

West Des Moines, IA 50266-3862]

Life Customer Contact Center – Tel [800 800 9882] Fax [800 531 0038]

AGENT/PRODUCER CODE:

AGENT/PRODUCER NAME:

(In this receipt, "Company" refers to the insurance company named above)

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, the Company's liability under this Agreement is limited to a refund of the total premium received.

DO NOT COLLECT CASH IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS \$3,000,000.

CONDITIONS AND LIMITATIONS

1. It is a condition precedent that the proposed insured be insurable on the START DATE. This means "insurable" under our rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the application or supplements.
5. This form is void if any check or draft is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
 - a. \$500,000 or the amount in Section D of the application, if the proposed insured is insurable at the rate applied for or better; or
 - b. \$100,000 or the amount in Section D of the application, if the proposed insured is insurable, but at a higher rate than applied for.
8. If the proposed insured dies by suicide, the Company's liability under this agreement is limited to a refund of the payment received.

START DATE

START DATE means the later of:

1. completion of all parts of the application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed.

STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by the Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

RECEIVED from [] Payment in the Amount of \$ []

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. ALL PREMIUMS AFTER THE FIRST ARE TO BE PROVIDED DIRECTLY TO THE COMPANY.

Signature of Proposed Insured

X

Signed at: City

State

Date Signed

/ /

Signature of Owner if other than the Proposed Insured

X

Signature of Licensed Agent/Producer

X

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK



Conditional Joint Life Insurance Agreement

[www.avivausa.com]



[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway

West Des Moines, IA 50266-3862]

Life Customer Contact Center – Tel[800 800 9882]Fax[800 531 0038]

ADDITIONS, DELETIONS, OR OTHER ALTERATIONS TO THIS AGREEMENT ARE STRICTLY PROHIBITED.

Insurance applied for on the Joint Life Insurance Application is provided by this form from the START DATE to the STOP DATE, as defined below. However, NO INSURANCE is provided unless ALL the CONDITIONS AND LIMITATIONS of this Agreement are met. If not met, Aviva Life and Annuity Company's liability under this Agreement is limited to a refund of the total premium received.

AGENT/PRODUCER: DO NOT COLLECT PREMIUM IF DEATH BENEFIT AMOUNT APPLIED FOR EXCEEDS \$3,000,000.

A. CONDITIONS AND LIMITATIONS

1. It is a condition precedent that both of the Proposed Insureds be insurable on the START DATE. This means "insurable" under Aviva Life and Annuity Company's rules and limits.
2. There is no insurance before the START DATE.
3. There is no insurance after the STOP DATE.
4. There is no insurance if any material misrepresentation exists on the Joint Life Insurance Application or supplements.
5. This form is void if any acceptable form of payment is not valid.
6. There is no insurance if less than a full month premium is paid.
7. Life Insurance limits are the lesser of:
 - a. \$500,000 or the amount in Section D of the Joint Life Insurance Application for amounts payable on the second death of the joint insureds, if both of the Proposed Insureds are insurable at the rate applied for or better; or
 - b. \$250,000 or the amount in Section D of the Joint Life Insurance Application for amounts payable on the second death of the joint insureds, if both of the Proposed Insureds are insurable, but at a higher rate than applied for.
8. If either of the Proposed Insureds dies by suicide, Aviva Life and Annuity Company's liability under this Agreement is limited to a refund of the payment received.

B. START DATE

START DATE means the later of:

1. completion of all parts of the Joint Life Insurance Application and supplements thereto; OR
2. the date any medical exam or other required medical studies or tests are completed for both of the Proposed Insureds.

C. STOP DATE

STOP DATE means the earliest of:

1. the date a non-acceptance notice is mailed by Aviva Life and Annuity Company; OR
2. the day before the policy date; OR
3. 60 days after the START DATE.

Received From	Payment in the Amount of \$
---------------	--------------------------------

All premium checks must be made payable to Aviva Life and Annuity Company. Do not make check payable to the agent/producer or leave payee blank. All premiums after the first are to be provided directly to Aviva Life and Annuity Company.

The Proposed Insured #1 is		Signature of Owner	
The Proposed Insured #2 is		Signature of Owner	
Signed at	State	Date (mm/dd/yy)	Signature of Agent/Producer
City		/ /	

PLEASE RETURN ONE COPY TO HOME OFFICE WITH CHECK



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Financial Questionnaire

[www.avivausa.com]



Mail or fax completed form to:

[P.O. Box 1555, Des Moines, IA 50306-1555] Fax:[800 531 0038]

[Aviva Life and Annuity Company]

[7700 Mills Civic Parkway, West Des Moines, IA 50266-3862]

The Company reserves the right to require additional documentation, tax returns and/or financial statements for verification.

Policy Number	Proposed Insured	Date of Birth (mm/dd/yy) / /
---------------	------------------	---------------------------------

INSTRUCTIONS—Personal Insurance Complete Section A and Section B

Business Insurance Complete Section A and Section C

A. PERSONAL ANNUAL EARNED INCOME

	Present Year	Previous Year
Salary & Wages	\$	\$
Bonus or Commissions	\$	\$
Dividends	\$	\$
Interest	\$	\$
Business Income	\$	\$
Real Estate Income	\$	\$
Trust Funds	\$	\$
Other (IRA's, pension, etc.)	\$	\$
Total Compensation or Net Earnings	\$	\$

1. Spouse's Earned Income: \$
2. Total amount of insurance inforce on spouse:
3. Total amount of insurance inforce on your life if the policy applied for is issued (after any existing policies are replaced, other pending application are accepted or declined, etc.)

B. PERSONAL INSURANCE

PERSONAL WORTH (Current Market Value)			
ASSETS		LIABILITIES	
Cash (Checking, Savings, CDs)	\$	Mortgage or Liens on Real Estate	\$
Accounts (Annuities, Bonds, Stocks)	\$	Notes & Accounts Payable	\$
Retirement Plans	\$	Unpaid Interest & Taxes	\$
Business Interest (Not Included Above)	\$	Credit Cards & Unsecured Debt	\$
Real Estate - Residence	\$	Long Term Debt & Future Obligations	\$
Real Estate - Other	\$	Other Liabilities (Describe)	
Other Assets (Describe)			\$
Total Assets	\$	Total Liabilities	\$
Estimated Estate Transfer Tax	\$	Total Assets - Total Liabilities	\$

1. Please explain below the source of funds for paying the premiums on the policy being applied for.
2. If creditor protection, please provide amount, purpose, date and duration of loan.
3. Please explain below the need for the coverage amount applied for and how the amount was determined.



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C. BUSINESS INSURANCE

1. Name of Company:
- a. Type of Insurance: ☐ Key Person ☐ Buy/Sell ☐ Stock Redemption
☐ Loan ☐ Deferred Comp ☐ Other
- b. Proposed Insured's Percent Ownership:
- c. What special skills, knowledge, or abilities does he/she possess which makes insurance necessary?

2. Key Person Title and Job Description:

3. Business Type: ☐ C Corp ☐ S Corp ☐ Partnership ☐ Sole Proprietorship ☐ LLC ☐ LLP

a. Description of Business (mfg, retail, etc.) . . .

4. Please attach a copy of your Company's latest financial statements (audited if possible) (Balance Sheet and Profit & Loss)

Current Company Book Value		Current Company Market Value	
Assets	\$	Market Value	\$
Liabilities	\$	Insured's % Ownership	%
Net Worth	\$	Market Value of Insured's % Ownership	%

5. How was the face amount requested calculated?

6. Company Net Profit (Before taxes and bonuses)

a. This Year (Estimate)

b. Previous Year

7. What other Stockholders, Partners, or Key Persons are also being insured in favor of the company?
(Provide name and amount)

8. Please provide reasons why other Stockholders, Partners or Key Persons are not seeking similar coverage:

9. Stock Redemption/Buy and Sell:

a. Is there a written agreement in effect? ☐ Yes ☐ No
(If yes, please provide a copy of the written agreement)

b. If no to 8.a, is a written agreement being contemplated? ☐ Yes ☐ No

Provide a reason why no agreement is in place:



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C. BUSINESS INSURANCE (continued)

10. Business Loan:

a. If loan/creditor protection, please provide amount, purpose, date and duration of loan:

--

b. Are others being insured for the same purpose? ☐ Yes ☐ Noc. Have any corporate obligations been personally guaranteed? ☐ Yes ☐ No

(If yes to any of the above, please provide amount and description)

11. Please provide any other details on the need or case design not discussed above:

12. References:

	Name	Address	Phone
Attorney:			
Accountant:			
Bank:			

C. SIGNATURES

It is represented that the answers and statements on this questionnaire are complete and true and correctly recorded.

I agree that a copy of this questionnaire shall be a part of the policy.

Signature of Proposed Insured X		Date (mm/dd/yy) / /
Producer's Name (please print)	Producer's Signature X	Producer's Telephone No.



* 1 8 5 1 6 0 6 1 3 0 3 *

State:	Arkansas	Filing Company:	Aviva Life and Annuity Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	Applications - 2013		
Project Name/Number:	Applications - 2013/Applications - 2013		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Readability Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certifications		
Comments:			
Attachment(s):			
AR Reg 19 Certification.pdf			
AR Reg 49 Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variability		
Comments:			
Attachment(s):			
EOV Applications - GENERIC.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Agent Reports (Filed for Informational Purposes Only)		
Comments:			
Attachment(s):			
15897 (6-13) AgentsReport FINAL.pdf			
17986 (6-13) AgentReportJointLife FINAL.pdf			

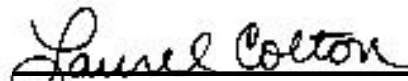
AR

ARKANSAS READABILITY CERTIFICATION

This is to certify that the following forms have achieved a Flesch Reading Ease Score of as indicated below and comply with the requirements of Arkansas Statute Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>FORM NUMBER</u>	<u>NAME</u>	<u>FLESCH SCORE</u>
18444 (6/13)	Life Insurance Application	52.9
18458 (6/13)	Joint Life Insurance Application	50.0
18465 (6/13)	Term Conversion Application	50.1
18472 (6/13)	Supplemental Application	50.1
18479 (6/13)	Non-Medical Questionnaire	50.4
18486 (6/13)	Medical Examination	51.9
15876 (6/13)	Conditional Life Insurance Agreement	50.5
18089 (6/13)	Conditional Joint Life Insurance Agreement	50.5
18516 (6/13)	Financial Questionnaire	54.1

Aviva Life and Annuity Company



**Laurel Colton, FLMI, ACS, AIRC
Director, Life Product Compliance**

01/10/2013

Date

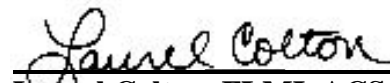
RD/CRT/AR

AR

**Arkansas Certification
Regulation 19**

I certify that this submission meets the provisions of Regulation 19, Section 10B, as well as all applicable statutes, regulations, and bulletins of the State of Arkansas.

Aviva Life and Annuity Company


Laurel Colton, FLMI, ACS, AIRC
Director, Life Product Compliance

01/10/2013
Date

Form Numbers

18444 (6/13) – Life Insurance Application
18458 (6/13) – Joint Life Insurance Application
18465 (6/13) – Term Conversion Application
18472 (6/13) – Supplemental Application
18479 (6/13) – Non-Medical Questionnaire
18486 (6/13) – Medical Examination
15876 (6/13) – Conditional Life Insurance Agreement
18089 (6/13) – Conditional Joint Life Insurance Agreement
18516 (6/13) – Financial Questionnaire

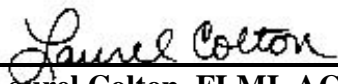
Regulation 19

AR

**Arkansas Certification
Regulation 49**

We have reviewed Regulation 49 against the issue procedures of the Company and certify that we are in compliance with the requirements of Regulation 49.

Aviva Life and Annuity Company


Laurel Colton, FLMI, ACS, AIRC
Director, Life Product Compliance

01/10/2013
Date

Form Number

18444 (6/13) – Life Insurance Application
18458 (6/13) – Joint Life Insurance Application
18465 (6/13) – Term Conversion Application
18472 (6/13) – Supplemental Application
18479 (6/13) – Non-Medical Questionnaire
18486 (6/13) – Medical Examination
15876 (6/13) – Conditional Life Insurance Agreement
18089 (6/13) – Conditional Joint Life Insurance Agreement
18516 (6/13) – Financial Questionnaire

Regulation 49

Aviva Life and Annuity Company

Summary of Bracketed Variable Material

All material that we consider “variable” is shown in brackets in the submitted document. Variable information is information that is unique to the specific application issued and information that can be changed for all new issues of the application without re-filing. This document summarizes the other variable material and explains the timing and basis for all potential variations.

Form Number/Name	Bracketed Information/Data Field	Explanation
18444 (6/13) Life Insurance Application	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18444 (6/13) Life Insurance Application	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18444 (6/13) Life Insurance Application	Tax Qualification Status	This section is marked as variable as the tax qualification statuses will either both be available or just one. If one is available, this section will not be applicable.
18444 (6/13) Life Insurance Application	Optional Coverage Riders Section	This section is marked as variable in the event we discontinue optional coverage riders.
18444 (6/13) Life Insurance Application	Primary Insured Rider Additional Insured Rider Child Rider	These items are marked as variable to enable us to discontinue, update the rider names and amount details, or add new riders and amount details without re-filing should any of these items change in the normal course of business.
18444 (6/13) Life Insurance Application	Riders That May Be Available on Universal Life Insurance Section	This section is marked as variable in the event we discontinue universal life insurance.
18444 (6/13) Life Insurance Application	Accelerated Access Wellness Life Protector Waiver of Monthly Deduction No Lapse Guarantee Accidental Death Benefit: Amount of Insurance:\$ Guaranteed Purchase Option: Option Amount: \$ Waiver of Specified Premium: Waiver Amount: \$	These items are marked as variable to enable us to discontinue, update the rider names and amount details, or add new riders and amount details without re-filing should any of these items change in the normal course of business.

18444 (6/13) Life Insurance Application	Riders That May Be Available on Term Life Insurance Section	This section is marked as variable in the event we discontinue term life insurance.
18444 (6/13) Life Insurance Application	Waiver of Premium Waiver of Premium Plus Accidental Death Benefit: Amount of Insurance:\$	These items are marked as variable to enable us to discontinue, update the rider names and amount details, or add new riders and amount details without re-filing should any of these items change in the normal course of business.
18444 (6/13) Life Insurance Application	Universal Life Death Benefit Option Section	This section is marked as variable in the event we discontinue universal life death benefit options.
18444 (6/13) Life Insurance Application	Death Benefit Return of Premium Rider	This item is marked as variable to enable us to discontinue, update the rider name and amount details, or add new riders and amount details without re-filing should this item change in the normal course of business.
18444 (6/13) Life Insurance Application	Levelized Strategy Transfer	This section is marked as variable in the event we discontinue levelized strategy transfers.
18444 (6/13) Life Insurance Application	Fraud Section	This item is marked as variable in the event that the District of Columbia changes or eliminates its fraud notification or in the event that another state using this application, changes its fraud notification regulation(s).
18458 (6/13) Joint Life Insurance Application	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18458 (6/13) Joint Life Insurance Application	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18458 (6/13) Joint Life Insurance Application	Tax Qualification Status	This section is marked as variable as the tax qualification statuses will either both be available or just one. If one is available, this section will not be applicable.
18458 (6/13) Joint Life Insurance Application	Optional Coverage Rider(s) Section	This section is marked as variable in the event we discontinue optional coverage riders.
18458 (6/13) Joint Life Insurance Application	Joint Term Rider	This item is marked as variable to enable us to discontinue, update the rider name and amount details, or add new riders and amount details without re-filing should this item change in the normal course of business.

18458 (6/13) Joint Life Insurance Application	Riders That May Be Available Section	This section is marked as variable in the event we discontinue additional available riders.
18458 (6/13) Joint Life Insurance Application	Estate Protection Life Protector Policy Split Option First Survivor Premium Rider: Initial Face Amount: \$__ Rider Duration No Lapse Guarantee	These items are marked as variable to enable us to discontinue, update the rider names and amount details, or add new riders and amount details without re-filing should any of these items change in the normal course of business.
18458 (6/13) Joint Life Insurance Application	If First Survivor Premium Rider Beneficiary Designation is different from Owner, please specify: Section	This section is marked as variable in the event we discontinue the First Survivor Premium Rider.
18458 (6/13) Joint Life Insurance Application	First Survivor Premium Rider	This section is marked as variable in the event we discontinue or change the name of the First Survivor Premium Rider or add another rider.
18458 (6/13) Joint Life Insurance Application	Death Benefit Return of Premium Rider	This item is marked as variable to enable us to discontinue, update the rider name and amount details, or add new riders and amount details without re-filing should this item change in the normal course of business.
18458 (6/13) Joint Life Insurance Application	Universal Life Death Benefit Option	This section is marked as variable in the event we discontinue or change the name for universal life death benefit options.
18458 (6/13) Joint Life Insurance Application	Levelized Strategy Transfer	This section is marked as variable in the event we discontinue levelized strategy transfers.
18458 (6/13) Joint Life Insurance Application	Fraud Section	This item is marked as variable in the event that the District of Columbia changes or eliminates its fraud notification or in the event that another state using this application, changes its fraud notification regulation(s).
18472 (6/13) Supplemental Application	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18472 (6/13) Supplemental Application	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18472 (6/13) Supplemental Application	Additional Insured Rider/Amount Children's Insurance Rider/Amount	These items are marked as variable to enable us to discontinue, update the rider names and amount details, or add new riders and amount details without re-filing should any of these items change in the normal course of business.

18472 (6/13) Supplemental Application	Fraud Section	This item is marked as variable in the event that the District of Columbia changes or eliminates its fraud notification or in the event that another state using this application, changes its fraud notification regulation(s).
18465 (6/13) Term Conversion Application	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18465 (6/13) Term Conversion Application	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18465 (6/13) Term Conversion Application	Tax Qualification Status	This section is marked as variable as the tax qualification statuses will either both be available or just one. If one is available, this section will not be applicable.
18465 (6/13) Term Conversion Application	Riders (Will require insurability if not on original policy) Section	This section is marked as variable in the event we discontinue this section or need to add or update riders.
18465 (6/13) Term Conversion Application	Universal Life Death Benefit Option 1: Level	This item is marked as variable to enable us to discontinue, update, or add to our death benefit options without re-filing should this item change in the normal course of business.
18465 (6/13) Term Conversion Application	Levelized Strategy Transfer	This section is marked as variable in the event we discontinue levelized strategy transfers.
18465 (6/13) Term Conversion Application	Fraud Section	This item is marked as variable in the event that the District of Columbia changes or eliminates its fraud notification or in the event that another state using this application, changes its fraud notification regulation(s).
18486 (6/13) Medical Examination Application	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18486 (6/13) Medical Examination Application	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18486 (6/13) Medical Examination Application	\$100,000 – up \$10,000 - \$99,999	These items are marked as variable in the event that the amount/range of insurance required for blood and urine samples change as per underwriting guidelines.

18479 (6/13) Non-Medical Life Insurance Application	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18479 (6/13) Non-Medical Life Insurance Application	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18516 (6/13) Financial Questionnaire	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18516 (6/13) Financial Questionnaire	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
15876 (6/13) Conditional Life Insurance Agreement	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
15876 (6/13) Conditional Life Insurance Agreement	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.
18089 (6/13) Conditional Joint Life Insurance Agreement	Aviva Aviva Life and Annuity Company	These items are marked as variable to enable us to update the company name and company logo without re-filing should this change through the course of business. Any such changes to the Company name will be submitted to the Department.
18089 (6/13) Conditional Joint Life Insurance Agreement	Company Home Office Address, Administrative Office Address, Company Website, Fax Number, and Phone Number	These items are marked as variable to enable us to update the policy without re-filing should any of these items change in the normal course of business. Any such changes to the Company address will be submitted to the Department as an informational filing.

Agent/Producer Report

www.avivausa.com



Aviva Life and Annuity Company

7700 Mills Civic Parkway

West Des Moines, IA 50266-3862

Life Customer Contact Center – Tel: 800 800 9882 Fax: 800 531 0038

AGENT/PRODUCER CODE:

AGENT/PRODUCER NAME:

AGENT INSTRUCTIONS

All questions must be completed in full. In this application, "Company" refers to Aviva Life and Annuity Company.

AGENT QUESTIONS

1. Does the Proposed Insured have any life insurance or annuity contract(s) currently active with our Company or any other company? ☐ Yes ☐ No
2. Will any annuity or life insurance presently or recently inforce be replaced or changed by this policy applied for? ☐ Yes ☐ No

If 2 is answered yes, please complete questions a-k, otherwise skip to question 3.

(State required replacement forms (Replacement Comparison, Notice or Statement) must accompany this application)

- a. What is the primary reason for the replacement?
 - b. Are you the writing Agent/Producer on the current policy(ies)? ☐ Yes ☐ No
 - c. When was the current policy(ies) issued?
 - d. With what underwriting classification was the current policy(ies) issued?
 - e. What are the current/proposed annualized premiums?
 - f. What are the current/proposed death benefit amounts?
 - g. What are the remaining surrender charges on the current policy(ies)?
 - h. Have you discussed/described the surrender charges and surrender charge period regarding the proposed policy? ☐ Yes ☐ No
 - i. If values from an existing annuity contract(s) are being used to pay premiums on the proposed policy, how has the original objective of the annuity contract(s) changed?
 - j. If values from an existing annuity contract(s) are being used to pay premiums on the proposed policy, have the tax implications been explained to the customer? ☐ Yes ☐ No
 - k. 1035 Exchange ☐ External ☐ Internal Attach 1035 forms
3. a. How long have you known the Proposed Insured?
 - b. Is the Proposed Insured a relative of or does the Proposed Insured have a business relationship with you? ☐ Yes ☐ No
If yes, explain
 - c. Did you personally see the Proposed Insured to be covered and were answers recorded exactly as given? ☐ Yes ☐ No
If no, explain and arrange for additional evidence of insurability
 - d. I personally viewed all driver's licenses or other government issued photo identification documents. ☐ Yes ☐ No
4. Does the Proposed Insured and Owner speak and understand English? ☐ Yes ☐ No



* 1 5 8 9 7 0 6 1 3 0 1 *

AGENT QUESTIONS (continued)

5. Was any other person present to answer questions? ☐ Yes ☐ No

If yes, who and why

6. a. **If the Proposed Insured is a minor dependent, complete for all brothers and sisters:**

Age	Sex	Amount of Life Insurance Inforce	Age	Sex	Amount of Life Insurance Inforce
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

b. Amount of life insurance inforce on each supporting parent or legal guardian \$

7. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than the insured, their family or employer? ☐ Yes ☐ No

If yes, explain

8. In the last 5 years, has the Owner or Proposed Insured sold a life insurance policy or annuity contract to a life settlement or viatical company, secondary market purchaser or investor? ☐ Yes ☐ No

9. Will any person or entity, other than a life insurance company, evaluate the Proposed Insured to provide any form of life expectancy evaluation? ☐ Yes ☐ No

10. Is the Proposed Insured an active duty (full-time) service member (officer or enlisted) of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard)? ☐ Yes ☐ No

11. Is the Owner an active duty (full-time) service member (officer or enlisted) of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard)? ☐ Yes ☐ No

If answering yes, please complete the Sale to Military Personnel Disclosure Form

12. Medical requirements arranged: ☐ Paramedical Exam ☐ EKG ☐ Blood Analysis ☐ Physician's Exam

Date Scheduled ☐ Check here if the exam has already been done.

Name & Phone number of vendor

13. If Married:

Spouse's Name Spouse's Occupation

Amount of life insurance in force on spouse \$ Spouse's annual earned income \$

14.a. Purpose of insurance ☐ Business ☐ Personal ☐ Estate

(If multi-purpose, give percentage of face or split the amount by purpose in the box below)

b. If Business: ☐ Deferred Comp ☐ Buy/Sell ☐ Split Dollar ☐ Key Person ☐ Premium Financing

☐ Other

Business net annual income \$ Business net worth \$

Proposed Insured's business life insurance inforce \$ % of ownership

Business life insurance issued or applied for on other owners, officers, partners or key person(s):

Name and Title	% of Business Owned	Insurance Company	Amount Inforce
<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>



* 1 5 8 9 7 0 6 1 3 0 2 *

ADDITIONAL INSURANCE

15. ☐ Additional policy: Amount \$ Plan
☐ Alternate policy: Amount \$ Plan

16. How did this sale originate?

AGENT CERTIFICATION

I certify that I saw and know the Proposed Insured to be the person described in this application. I reviewed the appropriate documents, and have truly and accurately recorded the information supplied by the Proposed Insured. I know of no condition affecting the eligibility or insurability of the Proposed Insured not fully set forth in the application. I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I am licensed in the state in which this application was completed. I have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. All state approved disclosure notices, statements or other information required by state or federal laws were given to the Owner at the time of application and only Company authorized sales materials were used.

I have read and understand Aviva's policies regarding Stranger Owned Life Insurance (STOLI) and Premium Financing, and to the best of my knowledge, the insurance policy being applied for does not violate the stated intent or spirit of either such policy. I have not promoted, been involved with and I am not aware of: (1) any planned sale or assignment of this insurance policy to a life settlement or viatical company, secondary market purchaser or investor, (2) any planned sale or assignment of any interest in a trust or entity that shall own or have interest in this insurance policy, or (3) any Owner, Proposed Insured or Beneficiary receiving or being offered money, future payments, "free insurance" or anything of value in connection with the insurance policy being applied for. I assume full responsibility for the delivery of the policy and the submission of the first premium.

List of all agents (please print)

Agent Code Number

Commission Share

Signed at:	Writing Agent Signature X	
Date:	Phone Number	Fax Number
E-Mail	Preferred mode of communication? <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Fax	



* 1 5 8 9 7 0 6 1 3 0 3 *

Agent/Producer Report for Joint Life Insurance Application

www.avivausa.com



Aviva Life and Annuity Company

7700 Mills Civic Parkway
West Des Moines, IA 50266-3862
Life Customer Contact Center – Tel: 800 800 9882 Fax: 800 531 0038

This Agent/Producer Report covers both Proposed Insureds. Where appropriate, please include information specific to each Proposed Insured.

1. a. Do the Proposed Insureds have any life insurance policy(ies) or annuity contract(s) currently active with Aviva Life and Annuity Company or any other company? ☐ Yes ☐ No
(If Yes, and if required by state regulation, any Replacement Comparison, Notice or Statement must accompany this application.)
- b. Will any life insurance policy(ies) or annuity contract(s) presently or recently in force be replaced or changed by this policy applied for? ☐ Yes ☐ No
if 1b is answered "yes", please complete the following questions i-xi, otherwise skip to question 2:
- i. What is the primary reason for the replacement?
- ii. Are you the writing Agent/Producer on the current policy(ies)? ☐ Yes ☐ No
- iii. When was the current policy(ies) issued?
- iv. With what underwriting classification was the current policy(ies) issued?
- v. What are the current/proposed annualized premiums?
- vi. What are the current/proposed death benefit amounts?
- vii. What are the remaining surrender charges on the current policy(ies)?
- viii. Have you discussed/described the surrender charges and surrender charge period regarding the proposed policy? ☐ Yes ☐ No
- ix. If values from an existing annuity contract(s) are being used to pay premiums on the proposed policy, how has the original objective of the annuity contract(s) changed?
- x. If values from an existing annuity contract(s) are being used to pay premiums on the proposed policy, have the tax implications been explained to the customer? ☐ Yes ☐ No
- xi. 1035 Exchange (attach required forms) ☐ External ☐ Internal
2. a. How long have you known the Proposed Insureds?
- b. Are the Proposed Insureds a relative of or do the Proposed Insureds have a business relationship with you? ☐ Yes ☐ No
If Yes, explain
- c. Did you personally see both of the Proposed Insureds to be covered and were answers recorded exactly as given? ☐ Yes ☐ No
If No, explain and arrange for additional evidence of insurability
- d. I personally viewed all driver's licenses or other government issued photo identification documents. ☐ Yes ☐ No
If no, please explain
3. Are the Proposed Insureds U.S. citizens? ☐ Yes ☐ No
If no, how long in U.S.? Type of Visa?
4. Was any other person present to answer questions? ☐ Yes ☐ No
If yes, who and why



* 1 7 9 8 6 0 6 1 3 0 1 *

5. Do the Proposed Insureds and the Owner speak and understand English? ☐ Yes ☐ No

If no, please explain

6. Will any policy issued as a result of this application have any portion of the initial or future premiums paid, or otherwise provided, by anyone other than an insured, their family or employer? ☐ Yes ☐ No

7. In the last 5 years, has any Owner or Proposed Insured sold a life insurance policy or annuity contract to a life settlement or viatical company, secondary market purchaser or investor? ☐ Yes ☐ No

8. Will any person or entity, other than a life insurance company, evaluate any Proposed Insured to provide any form of life expectancy evaluation? ☐ Yes ☐ No

If answering yes to questions 6, 7 or 8, please provide details of the financing, sale or evaluation in question 15.

9. Is the Proposed Insured an active duty (full-time) service member (officer or enlisted) of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard)? ☐ Yes ☐ No

10. Is the Owner an active duty (full-time) service member (officer or enlisted) of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard)? ☐ Yes ☐ No

If answering yes, please complete the Sale To Military Personnel Disclosure Form

11. Medical requirements arranged: ☐ Paramedical Exam ☐ EKG ☐ Blood Analysis

☐ Physician's Exam Date Scheduled

☐ Check here if the exam has already been done

Name & Phone # of vendor

12. Complete the following information only if a Spouse is other than a Proposed Insured:

Proposed Insured #1, Information about Spouse	Proposed Insured #2, Information about Spouse
Name	Name
Occupation	Occupation
Amount of life insurance inforce	Amount of life insurance inforce
Annual earned income	Annual earned income

13. a. Purpose of insurance ☐ Business ☐ Personal ☐ Estate

(If multi-purpose, give percentage of face or split the amount by purpose in remarks section below.)

b. If Business: ☐ Deferred Comp ☐ Buy/Sell ☐ Split Dollar ☐ Key Person

☐ Other

Business net annual income \$

Business net worth \$

Proposed Insureds Business life insurance inforce \$

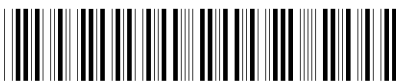
% of ownership

Business life insurance issued or applied for on other Owners, Officers, Partners or Key Person(s):

Name and Title	% of Business Owned	Insurance Company	Amount in Force
			\$
			\$
			\$
			\$

14. ☐ Additional ☐ Alternate policy: Amount \$

Plan



* 1 7 9 8 6 0 6 1 3 0 2 *

15. Remarks

AGENT/PRODUCER'S CERTIFICATION

I certify that:

- I saw and know both Proposed Insureds to be the persons described in this application;
- I reviewed the appropriate documents, and have truly and accurately recorded the information supplied by both Proposed Insureds;
- I know of no condition affecting the eligibility or insurability of both Proposed Insureds not fully set forth in the application;
- I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy;
- I am licensed in the state in which this application was completed;
- I have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations;
- All state approved disclosure notices, statements or other information required by state or federal laws were given to the Owner at the time of application and only company authorized sales materials were used;
- I have read and understand Aviva's policies regarding Stranger Originated Life Insurance ("STOLI") and Premium Financing, and to the best of my knowledge, the insurance policy being applied for does not violate the stated intent or spirit of either such policy;
- I have not promoted, been involved with and I am not aware of: (1) any planned sale or assignment of this insurance policy to a life settlement or viatical company, secondary market purchaser or investor, (2) any planned sale or assignment of any interest in a trust or entity that shall own or have interest in this insurance policy, or (3) any Owner, Proposed Insured or Beneficiary receiving or being offered money, future payments, "free insurance" or anything of value in connection with the insurance policy being applied for, and;
- I assume full responsibility for the delivery of the policy and the submission of the first premium.

Agency No.	Agency Name
------------	-------------

List of all Agents/Producers (please print)	Agent/Producer code #	Commission share

Signed at		
Signature (Writing Agent/Producer)		Date (mm/dd/yy)
X		/ /
Phone #	E-Mail	Fax #

Preferred mode of communication? ☐ Phone ☐ E-Mail ☐ Fax

How did this sale originate?

